PPO PLAN BENEFIT SUMMARY
FOR
INDIVIDUALS WHO RETIRED *ON OR AFTER* 3-1-13

This document is meant as a summary description of basic benefit coverage. It cannot add to or take away from any legal plan. This document describes the benefit program in general terms. It is not intended to be a complete description of coverage.

THE CITY'S HEALTH INSURANCE PLAN HAS THE FOLLOWING EXCLUSIONS: Dental care, cosmetic surgery unless medically necessary, eyeglasses, contact lenses, dentures, hearing aids for adults, custodial or domiciliary care, experimental medical procedures, examinations for employment, sports or purchase of insurance, care required while in government operated facility or services required while incarcerated or in military service. Refer to your Benefit Booklet for further details.

	IN NETWORK SERVICES ANTHEM ***Blue Priority*** provider network for services within Wisconsin Service Area. ANTHEM ***National PPO (BlueCard PPO)*** for services outside of Wisconsin.	**OUT OF NETWORK SERVICES**
MAXIMUM COVERAGE	No dollar limit. *Payment of services will depend on how providers bill.*	No dollar limit. *Payment of services will depend on how providers bill.*
DEDUCTIBLE	Unless otherwise noted, deductibles of $100 per person or $300 per family per Plan year for medical services (excludes Routine Preventative Services and Copays).	Unless otherwise noted, deductibles of $15,000 per person or $30,000 per couple/family per Plan year for combined medical and prescription drug services.
COINSURANCE (PERCENT OF COVERED CHARGES)	100% of eligible charges after applicable deductible/copays have been satisfied.	Unless otherwise noted, the Plan pays 80% of eligible charges after the deductible has been satisfied.
ANNUAL OUT-OF-POCKET (LIMIT ON EXPENSES)	Maximum out-of-pocket coinsurance, including all applicable copays (excluding prescription drug copays) is $4,850 per person or $9,700 per couple/family per Plan year.	Maximum out-of-pocket coinsurance (including the deductible) is $30,000 per person or $60,000 per couple/family per Plan year; thereafter, the Plan pays 100% of eligible charges.
PHYSICIAN OFFICE VISITS	**$20** Primary Care Physician office visit co-pay (Family Practice, General Practitioner, Pediatrician, Internal Medicine, OB/GYN, GYN, Certified Nurse Midwife, Nurse Practitioner, Physician Assistant, and Clinical/Multi-specialty Group). **$40** Specialist visit copay (qualified practitioners not listed above). **Note**: Co-pays are waived for Routine Preventative Services.	80% of eligible charges after deductible.
24/7 Nurseline	Available 24 hours a day, 7 days a week at no cost.	
EMERGENCY CARE	Subject to a $150 copay per emergency, then 100% of eligible charges after deductible. Copay waived if admitted inpatient or transported by ER vehicle.	Emergency services paid same as in network services. Non-emergency services paid at 80% after deductible.
URGENT CARE FACILITY	100% of eligible charges after deductible if billed as "urgent care" visit. Member subject to applicable copay (i.e., $20 or $40 Specialist copay if billed as "office visit"; $150 copay if billed as "emergency visit").	80% of eligible charges after deductible.
AMBULANCE	100% of eligible charges after deductible when medically necessary.	80% of eligible charges after deductible.
HOSPITALIZATION	100% of eligible charges after deductible.	80% of eligible charges after deductible.
SURGICAL CARE OR SURGERY	100% of eligible charges after deductible.	80% of eligible charges after deductible.
PHYSICIAN VISITS IN HOSPITAL	100% of eligible charges after deductible.	80% of eligible charges after deductible.

	IN NETWORK SERVICES	OUT OF NETWORK SERVICES
ROUTINE PREVENTATIVE CARE: Women's Health Services; Routine Adult Physicals; Well Child Care; Immunizations (Child & Adult); Flu Shots; Diagnostic X-Rays and Lab Tests; Colon Cancer Screening; Prostate Cancer Screening; Pap Smear; Mammography; Vision Exam; Hearing Exam	100% of eligible charges; deductible/copay is waived.	Not covered.
INJECTIONS	100% of eligible charges after deductible.	80% of eligible charges after deductible.
ALLERGY CARE	100% of eligible charges after deductible.	80% of eligible charges after deductible.
DIAGNOSTIC X-RAY, LAB SERVICES (Non-Routine)	100% of eligible charges after deductible.	80% of eligible charges after deductible.
PODIATRY SERVICES (Non-Routine)	100% of eligible charges after deductible.	80% of eligible charges after deductible.
HEARING EXAM (Non-Routine)	100% of eligible charges after deductible.	80% of eligible charges after deductible.
EYE EXAM (Non-Routine)	100% of eligible charges after deductible.	80% of eligible charges after deductible.
MATERNITY	Hospital & physician charges covered at 100% of eligible charges after deductible.	80% of eligible charges after deductible.
PEDIATRIC CARE (Non-Routine)	100% of eligible charges. Subject to applicable copay.	80% of eligible charges after deductible.
HEALTH EDUCATION & COUNSELING (Non-Routine)	100% of eligible charges after deductible.	80% of eligible charges after deductible.
ORAL SURGERY	100% of eligible charges after deductible for initial treatment for injury to sound, natural teeth and for specific diseases, including removal of partially or completely unerupted impacted teeth.	80% of eligible charges after deductible for initial treatment for injury to sound, natural teeth and for specific diseases, including removal of partially or completely unerupted impacted teeth.
THERAPIES – CARDIAC, CHEMO, DIALYSIS/ HEMODIALYSIS, INFUSION RADIATION, AND RESPIRAORY (Inpatient/Outpatient)	100% of eligible charges after deductible.	80% of eligible charges after deductible.
CHIROPRACTIC CARE	100% of eligible, medically necessary charges after deductible. ***Provider must be able to document improvement in the condition as Anthem requires review after 15 visits.***	80% of eligible, medically necessary charges after deductible.
PHYSICAL THERAPY	100% of eligible, medically necessary charges after deductible. **NOTE:** Subject to applicable copay if provider bills as an office visit; if billed as a physical therapy appointment, copay will not apply. ***Provider must be able to document improvement in the condition as Anthem requires review after 15 visits.***	80% of eligible, medically necessary charges after deductible.
OCCUPATIONAL THERAPY	100% of eligible, medically necessary charges after deductible. ***Provider must be able to document improvement in the condition as Anthem requires review after 15 visits.***	80% of eligible, medically necessary charges after deductible.

<table>
<tr><th></th><th>IN NETWORK SERVICES</th><th>OUT OF NETWORK SERVICES</th></tr>
<tr><td>MENTAL HEALTH & ALCOHOL/ SUBSTANCE ABUSE:

Inpatient, Residential

Outpatient Therapy and Office Visit Services

Partial Hospitalization</td><td>

100% of eligible charges after deductible.

100% of eligible charges; deductible is waived. Subject to applicable copay.

100% of eligible charges after deductible.</td><td>80% of eligible charges after deductible.</td></tr>
<tr><td>DURABLE MEDICAL EQUIPMENT</td><td>100% of eligible charges after deductible for initial purchase or rental when authorized; does not cover repair or replacement.</td><td>80% of eligible charges after deductible for initial purchase or rental when authorized; does not cover repair or replacement.</td></tr>
<tr><td>DEPENDENT COVERAGE</td><td colspan="2">Refer to the last page of this document for details.</td></tr>
<tr><td>COORDINATION OF BENEFITS</td><td colspan="2">Benefits under this Plan are coordinated with benefits provided by other plans for which you and/or your dependents are also covered. Refer to the Coordination of Benefits section in your Benefit Booklet for details.</td></tr>
<tr><td>PRE-CERTIFICATION</td><td colspan="2">Required for non-emergency Inpatient Hospital Admissions (includes Mental Health, Alcohol/Substance Abuse), Surgical Procedures, Outpatient Care, Skilled Nursing Facility, Home Health Care, and Hospice Care.</td></tr>
<tr><td>PRESCRIPTION DRUGS</td><td>IN NETWORK SERVICES
Retail: Express Scripts, Inc.
Mail Order: Express Scripts, Inc.</td><td>OUT OF NETWORK SERVICES</td></tr>
<tr><td></td><td>Cost per prescription or refill; up to 34-day retail supply and 90-day mail order supply (includes insulin & diabetic supplies).

Prescriptions are not subject to the annual deductible.
<table>
<tr><th></th><th>Retail</th><th>Mail Order</th></tr>
<tr><td>Low cost generic and brand name drugs on Plan Manager’s Drug List</td><td>$15</td><td>$37.50</td></tr>
<tr><td>High cost generic and brand name drugs on Plan Manager’s Drug List</td><td>$25</td><td>$62.50</td></tr>
<tr><td>Generic and brand name drugs not on Plan Manager’s Drug List</td><td>$35</td><td>$87.50</td></tr>
<tr><td>Specialty Medications</td><td colspan="2">5% copay with maximum of $100 per script per month.</td></tr>
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Maximum out of pocket for all prescription tiers combined is $1,500 per person or $3,000 per couple/family per Plan year.

Note: Prescriptions for equipment/items deemed medically necessary (such as, but not limited to, crutches, compression stockings, nebulizers, diabetic meters, etc.) are covered under the Durable Medical Equipment section and track toward the annual medical out-of-pocket limit on expenses.</td><td>80% of charges per prescription or refill up to a 34-day supply after deductible.</td></tr>
<tr><td>TELEMEDICINE</td><td>IN NETWORK SERVICES
Anthem’s LiveHealth Online</td><td>OUT OF NETWORK SERVICES</td></tr>
<tr><td></td><td>100% of eligible charges, subject to Primary Care Physican copay.</td><td>80% of eligible charges after deductible.</td></tr>
</table>

The City reserves the right to make changes to coverage if future non-discrimination testing rules or plan structure makes it impossible to provide coverage.

Dependent means a covered **employee's**:

1. Legally recognized spouse;
2. Natural blood related child, step-child, legally adopted child or a child under **your** legal guardianship as determined with a court decree whose age is less than the limiting age. Each child must legally qualify as a **dependent** as defined by the United States Internal Revenue Service guidelines or applicable State Statutes.

   Limiting age and eligibility criteria:

   Dependent children under age 26 (as required by federal and state mandates):

   The limiting age for each **dependent** child is the end of the month he or she attains the age of 26 years, regardless if the child is:

   a. Married;
   b. A tax dependent;
   c. A student;
   d. Employed;
   e. Residing with or receives financial support from *you*; or
   f. Eligible for other coverage through employment.

   Dependent child, age 26 and older (as required by State mandate), who is called to federal active duty:

   The limiting age is any age for each **dependent** child age 26 and older when they meet the requirements outlined below. **Dependent** termination is the end of the month they no longer meet these requirements.

   - The child is a full-time student; and
   - The child was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending an institution of higher education on a full-time basis; and
   - The child was under age 27 when called to federal active duty; and
   - The child applies for full-time student status at an institution of higher education up to 12 months after completing active duty; and
   - If the child is called to active duty more than once within a four-year period of time, the child's age at the time of their first call to active duty will be used when determining eligibility under this Plan.

3. A covered **employee's** child whose age is less than the limiting age and is entitled to coverage under the provisions of this Plan because of a medical child support order;
4. Grandchild, as long as the **employee's** covered **dependent**, who is the parent of the grandchild, is not yet age 18.

You must furnish satisfactory proof to the **City** upon request that the above conditions continuously exist. If satisfactory proof is not submitted to the **City**, the child's coverage will not continue beyond the last date of eligibility.

A covered **dependent** child who attains the limiting age while covered under the Plan will remain eligible for medical benefits if all of the following exist at the same time:

1. Permanently mentally disabled or permanently physically handicapped;
2. Incapable of self-sustaining employment;
3. The child meets all of the qualifications of a **dependent** as determined by the United States Internal Revenue Service;
4. Unmarried.

You must furnish satisfactory proof to the **City** that the above conditions continuously exist on and after the date the limiting age is reached. The **City** may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to the **City**, the child's coverage will not continue beyond the last date of eligibility.